CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 780 (3-2006)

Clear Fields

EXTERNAL INFUSION PUMP

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

1. Mark the pump which has been prescribed:
   ☐ External Infusion Pump (non-disposable) ☐ Implantable infusion pump

2. Provide the HCPCS code for the drug that requires the use of the pump.

3. If non-specific code was used to answer question #2, print name of drug.

4. Mark the route of the administration.
   ☐ Intravenous ☐ Subcutaneous

5. Mark the method of administration.
   ☐ Continuous ☐ Intermittent ☐ Bolus

6. What is the total time duration of drug infusion per 24 hours? (1-24)

7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?
   ☐ Yes ☐ No ☐ Does Not Apply

SECTION C - Narrative Description

Narrative decription of all items, accessories and options ordered.

SECTION C Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)